

NOTICE OF PRIVACY PRACTICES AND CONSENT

Midnight Sun Smiles, LLC

Evan G. Young, DDS

Form PP, Edition Date 7/1/2012

This document has been prepared for your review as it relates to privacy matters in this office. When you are accepted as a patient in this practice, you are asked to provide us with several items of information about yourself, your spouse, your dependent children and many other items about your employment and other personal information. These include, but are not necessarily limited to, your name, address, phone numbers, place of employment, insurance coverage, relationships to various other people on your account, chart records, prescriptions, etc. Collectively, this information is referred to as your health information. The purpose of this document is to explain how this information will be used in this office and when certain information will be disclosed, how it is disclosed and your rights to the information gathered. Every patient that is 18 years or older will be asked to review and sign this Notice.

OUR LEGAL DUTY

We are required by applicable federal and state laws to maintain the privacy of your health information. We are also required to give you (and each person in your family who is 18 years or older) this Notice about the privacy practices in this office and your rights concerning your health information. We must follow the privacy practices described in this Notice while it is in effect, and we reserve the right to change any information contained in this Notice at any time, provided such changes are permitted by applicable law. You will be provided a new Notice if such changes become necessary.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

We use and disclose health information about you for treatment and payment. For example, with regards to treatment, we may use or disclose your health information to a physician or other healthcare provider that provides treatment to you, or to another healthcare provider to whom you are being referred for specific treatment. As for payment matters, we may use and disclose your health information to obtain payment for services we provide to you, whether payment is to be made to our office or directly to you.

You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by this Notice.

In addition to the above, the following uses and disclosures of your health information are permitted under this Notice:

- ***To Your Family and Friends:*** We must disclose your health information to you, as described in the *Patient's Rights* section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
- ***Persons Involved in Care:*** We may use or disclose health information to notify, or assist in the notification (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.
- ***Marketing Health-Related Services:*** We will not use your health information for marketing purposes.
- ***Required by Law:*** We will use or disclose your health information when we are required to do so by law.
- ***Abuse or Neglect:*** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
- ***National Security:*** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials, health information required for lawful intelligence, counter intelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain

circumstances.

- **Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, email, text messages or letters).

PATIENT RIGHTS

The following list describes your rights regarding the protection of your health information:

- **Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot reasonably do so. Any requests for copies of your health information must be in writing in the form of a letter from you or a form provided by our office, either of which must be sent to the address provided at the end of this Notice. We will provide you with one copy of your health information at no charge. The cost for each additional copy will be \$25, payable at the time the additional copy is picked up. If you request a copy of your health information in a format other than a photocopy, the charge for the first and subsequent copies will be \$25 per copy.
- **Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, a charge of \$25 for each additional request.
- **Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).
- **Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations, but such a request must be made in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
- **Amendment:** You have the right to request that we amend your health information. Your request must be in writing and must explain why the information should be amended. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint upon request.

We support the right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Evan G. Young, DDS

Address: 2000 Abbott Road, Suite 100, Anchorage, AK 99507

Telephone: (907) 349-5585 *Fax:* (907) 522-1663 *Email:* aksmiles@proton.me

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

- **Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.
- **Notice of Privacy Practices:** We reserve the right to change our privacy practices as described above. If we change our privacy practices, we will issue a revised Notice of Privacy Practices form that will contain the changes. Those changes may apply to any of your protected health information that we maintain.
- **Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation to the Contact Officer noted above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE: Your signature on the "Patient Information" form indicates that you have had full opportunity to read and consider the contents of this Notice of Privacy Practices and this Consent form. I understand that, by signing the Patient Information form, I am giving my consent to Dr. Young's use and disclosure of my protected health information to carry out

treatment, payment activities and health care operations.

Evan G. Young, DDS

Form PP, Edition Date 4/1/2024